2nd Quarter review Name:

# Positioning the person

* Regular position changes & good alignment promote comfort & well-being. Breathing is easier. Circulation is improved. Pressure ulcers & contractures are avoided.
* Whether in bed or chair, all residents must be repositioned at least q2°.
  + Get adequate help
  + Explain procedure, provide privacy
  + Be gentle when moving the resident
  + Use pillows to support body parts & provide good alignment for comfort
  + Complete safety check & provide call light
* **Fowler’s position** is semi-sitting with HOB45 - 60°. Knees may be slightly .
* **Supine (dorsal recumbent) position** is the back-lying position.
* **Prone position** is lying on abdomen with head turned to one side.
* **Lateral (side-lying) position** is lying on one side or the other.
* **Sim’s position** is a semi-prone, left side-lying position.
* **Sitting in a chair** must be with upper body & head erect.
  + **Back & buttocks** against back of chair.
  + **Feet** flat on floor or on wheelchair footplates, never unsupported.
  + **Backs of knees & calves** are slightly away from edge of seat.

# Moving the person

* To prevent work-related injuries:
  + Plan, prepare, & get help.
  + Tell the resident what he/she can do to help. Give clear, simple instructions.
  + Do not grab the person under the arms. Use assistive equipment & devices.
  + Wear shoes that provide good traction.
* Protect the resident’s skin from **shearing** & **friction** by:
  + Rolling
  + Using a lift (turning) sheet.
  + Using slide boards, slide sheets, or large incontinence product to assist.
* Moving a person in bed. ✓ with nurse or care plan to know:
  + Position limits & restrictions; how far you can lower HOB; limits on person’s ability to move.
  + What equipment is needed: mechanical lift, trapeze, lift or slide sheet.
  + How much help is needed.
  + If person uses side rails.
  + Report & record: how much help was needed, who helped, how person tolerated move, how positioned, c/o discomfort or pain.
* Moving person up in bed
  + Can sometimes move lightweight up in bed alone if they can assist & use a trapeze. 2 or more staff needed for heavy & very weak people.
  + Use drawsheet, turning pad, slide sheet, or large incontinence product to reduce **shearing** & **friction.**
* Turning persons helps prevent complications from bedrest. Some procedures & care measures require side-lying position. Use pillows to support
* **Logrolling** is turning the person as a unit, in alignment with spine straight, with one motion.
* **Dangling** (sitting on side of bed)
  + **Postural (orthostatic) hypotension** is dizziness or faintness due to a drop in BP when a person gets out of bed too fast. It is prevented by gradually  activity in stages: Bedrest **dangling** sitting in chair walking.
  + While dangling, the person coughs & deep breathes, moves legs back & forth in circles to stimulate circulation.
  + Observations to report & record include: pulse & respirations; c/o dizziness, lightheadedness, or SOB; length of time dangled: how much help needed; how tolerated.
* Transferring person to chair, W/C, stretcher, or back to bed
  + Arrange furniture so there is enough space in the room
  + Lock wheels on bed, W/C, stretcher
  + Make sure person is in good alignment after the transfer
  + Strong side moves first, destination (bed, W/C, stretcher, chair) on strong side of resident
  + Use transfer (gait) belt for transfer & repositioning. Person must not put his/her arms around your neck.
  + Person must wear non-skid footwear
* Mechanical lift – used for people unable or too heavy for staff to transfer
  + Must be trained before using any equipment
  + Sling, straps, hooks must be in good repair
  + Weight must not exceed limit of equipment
  + 2 staff members required
  + Must follow the manufacturer’s instructions
  + Residents commonly fear falling – explain & demonstrate to reassure

# The resident’s unit

* Unit includes personal space, furniture, & equipment provided by nursing center. Unit should be as personal & home-like as possible.
* Temperature: higher temperatures & protection from drafts needed for comfort when ill &/or elderly
  + Keep room temp
  + Provide appropriate clothing, lap robes to cover legs, blankets
  + Cover with bath blankets when giving care
  + Protect residents from drafty areas
* Minimize odors
  + Empty, clean, & disinfect bedpans, urinals, commodes, & kidney basins promptly
  + Be sure toilets are flushed
  + ✓ incontinent people frequently
  + Δ wet & soiled linen promptly
  + Keep laundry containers closed
  + Dispose of incontinence products promptly
  + Hygiene measures to prevent body & breath odor
* Decrease noises
  + Control voice
  + Handle equipment carefully, keep in good working order
  + Answer call lights, signal lights, & intercoms promptly
* Lighting should be adjusted to meet residents’ needs. Bright light is cheerful & needed for those with vision problems. Dim light is better for rest & relaxation. Light controls should be within the resident’s reach.
* Bed should be raised to give care, in lowest position when not giving care.
  + Bed wheels should always be locked, unless moving the bed
  + Bed rail use must be directed by nurse & care plan
  + Bed positions include:
    - **Flat**
    - **Fowler’s**: Semi-sitting; HOB45° - 60°.
    - **High-Fowler’s**: HOB60° - 90°.
    - **Semi-Fowler’s**: HOB30°. Some agencies  knees 15°.
    - **Trendelenberg’s**: HOB, foot of bed. Requires MD order.
    - **Reverse Trendelenberg’s**: HOB, foot of bed . Needs MD order.
  + **Entrapment** occurs when resident gets caught in spaces between bed rails, mattress, bedframe, headboard, or footboard. Report risks, if detected. If a person is entangled, try to release person & notify nurse at once.
* **Overbed table & bedside stand:** Keep clean. Use only with clean or sterile items; never place bedpans, urinals, or soiled linen on top of bedside stand.
* **Privacy curtain**: must always be pulled completely around the bed before care
* **Call system**: Must always be within reach: in bed, bathroom, shower
  + Within reach of strong side.
  + Remind resident to call when help is needed.
  + Answer signal lights promptly, immediately if person is in bathroom or shower.
* Closet/ drawer space must be freely accessible to resident. Agency may inspect contents if hoarding is suspected. Person must be informed of inspection & give permission to open or search closer or drawers. Always have co-worker present.

# Bedmaking

* Clean, dry, wrinkle-free linens promote comfort & prevent skin breakdown & pressure ulcers.
  + Straighten whenever loose or wrinkled & at bedtime.
  + Check for food & crumbs after meals.
  + Change whenever wet, soiled, or damp.
  + Check linens for dentures, glasses, hearing aids, sharp objects.
* Types of beds:
  + **Closed**: top linens not folded back. Bed ready for new resident or not in use until bedtime.
  + **Open**: top linens fan-folded so person can get in bed. Ready for use.
  + **Occupied**: made with person in it.
  + **Surgical**: made to transfer person from stretcher or arriving by ambulance.
* Linens: collect only enough, do not bring extra linen into resident’s room. Once in the room it is considered contaminated & can’t be used for another resident.
  + Roll each piece of dirty linen away from you, so side that was in contact with resident is inside the roll, away from you.
  + Always hold linen away from your body & uniform.
  + Never shake linen.
  + Clean linen is placed on clean surface.
  + Never put clean or dirty linen on the floor.
  + Practice medical asepsis.
  + Use good body mechanics. Save time by working with a co-worker.

# Hygiene

* Culture & personal choice influence hygiene practices. Most people have personal routines & habits. Protect privacy.
* Good hygiene cleanses, prevents body & breath odors, relaxes,  circulation.
* Oral hygiene prevents mouth odors & infections, improves comfort, improves taste of food, reduces risk of **periodontal** disease & cavities.
  + Set up & assist people to brush teeth (as needed) after meals & sleep & at bedtime. Follow care plan.
  + Floss after brushing, if only once per day, bedtime is best.
  + Denture care: usually removed at bedtime. Slippery when wet, so hold firmly & line sink with towel to prevent damage. Use labeled denture cup & remind residents not to wrap them in tissues. Store in cool water or denture soaking solution (follow manufacturer’s directions). Hot water causes dentures to lose shape. Many people don’t like to be seen without their dentures.
  + Mouth care for unconscious person given at least q2° (follow care plan) to help prevent infection & keeps mouth clean & moist. Use sponge swabs with small amount of cleaning agent. Position person on side with head turned to prevent aspiration. Use padded tongue blade to keep person’s mouth open. Apply lubricant to lips.
  + Report dry, cracked, swollen, or blistered lips &/or bleeding, redness, swelling, sores on gums, in mouth, or on tongue. Loose teeth, mouth or breath odor, white patches on mouth or tongue, & rough, sharp, or chipped areas son dentures should also be reported.
* Bathing cleanses, refreshes, relaxes, stimulates circulation, & exercises body parts. It provides an opportunity to make observations & talk to the resident.
  + Water temp for complete & partial bed baths is 110°F & 115°F. Elderly with fragile skin may need lower temps.
  + Soap dries skin, so elderly usually only need a complete bath or shower twice per week. Thorough rinsing is important when soap is used. Lotions & oils help keep skin soft.
  + Report & record: rashes, bruises, open areas, pale or reddened areas (esp over boney parts), swelling of feet or legs, dry skin, corns or calluses on feet, unusual skin temp or c/o pain or discomfort.
  + Powder use requires extreme caution. Do not use powder near persons with respiratory problems. Never shake powder onto person. Sprinkle small amount onto your hands or a cloth while turned away from the person. Apply thin layer. Be sure powder doesn’t get on floor as it can make floors slippery 7 cause falls.
  + **Complete bed bath** involves washing the resident’s entire body in bed. First, wipe from inner to outer aspect of each eye with clean part of soap-free wet washcloth. Ask person if you should use soap to wash face. Work from cleanest to dirtiest areas, top to bottom approach. Finish with genital area, allow person to partiipate as much as possible. Give back massage after bath. Apply lotion, deodorant or antiperspirant, &/or powder as requested. Comb or brush hair. Empty & clean wash basin.
  + **Partial bath** involves washing face, hands, axillae (underarms), back, buttocks, & perineal area. Assist the person as needed.
  + Tub bath can cause person to feel faint, weak, or tired. Water temp is usually 105°F. Report & record any weakness or lightheadedness. Person may need transfer bench, tub with side entry door, or a mechanical lift to get in & out of tub.
  + Never let weak or unsteady persons stand in the shower. Risk to fall in shower is minimized by use of shower chairs, grab bars, shower mats or other non-skid surfaces. Protect privacy in shower rooms with multiple stations. Properly screen & cover the person.
* Back massage relaxes muscles & stimulates circulation.
  + Usually given after bath & with HS cares. Can also be provided when repositioning a person.
  + Observe skin for breaks, bruises, reddened areas. Report & record.
  + Lotion reduces friction – should be warmed before applying to skin.
  + Use firm strokes, keeping hands in contact with skin.
  + After massage, apply lotion to elbows, knees, & heels.
  + Do not massage reddened bony areas. Massage can lead to more tissue damage.
  + Wear gloves is skin is not intact. Follow standard precautions.
  + Back massages are dangerous for persons with certain heart diseases, back injuries, skin diseases, & lung disorders. Check with nurse & care plan before giving back massage to persons with these conditions.
* Perineal care is done daily during bath & whenever area is soiled by urine or feces.
  + Most people do not understand the term “perineal” or “perineum”. Use terms people understand. Most people understand “privates”, “private parts”, “genitals”, “crotch”, or “area between the legs”.
  + Work from cleanest area to dirtiest [urethra (cleanest)anal (dirtiest)] area. Work frontback.
  + Use warm water with washcloths, towelettes, cotton balls or swabs according to agency policy. Rinse thoroughly. Pat dry. Water temperature is usually 105°F - 109°F.
  + Report & record: bleeding, redness, swelling, irritation, odor, skin breakdown, discharge from vagina or urinary tract, complaints of pain or burning, signs of urinary or fecal incontinence.

# Grooming

* Hair care, shaving, nail & foot care prevent infection & promote comfort, but also affect love, belonging, & self-esteem needs.
* Care plan for hair care should reflect person’s culture, personal choices, skin/scalp condition, health history, & self-care ability.
  + Never cut hair for any reason. Inform nurse if you think haircut is needed.
  + Place towel across person’s back & shoulders to protect garments when brushing & combing hair. In bed, provide hair care before changing linens & pillowcase. Begin at scalp & work toward hair ends. With tangles & matting, may need to start at ends & work toward scalp. Special measures are needed for curly, coarse, & dry hair. ✓ care plan.
  + Shampooing depends on person’s needs & preferences, usually done weekly on person’s bath or shower day. Keep shampoo out of eyes – have person hold washcloth over eyes. Report: scalp sores (wear gloves), flaking, itching, presence of nits or lice, patches of hair loss, very oily or very dry hair, matted or tangled hair, how person tolerated shampooing.
* Wash & comb mustaches & beards daily & prn. Never trim without person’s consent.
* Shaving legs & underarms varies among cultures, & should be done after bathing when skin is soft.
* Nail & foot care prevents infection, injury, & odors.
  + Easiest to trim right after soaking or bathing.
  + Use extreme caution when using clippers to cut fingernails, never scissors.
  + When soaking feet, exercise caution with residents with decreased sensation or circulatory problems, as they are easily burned.
  + Nurse or podiatrist cuts toenails & provides foot care for people with diabetes, poor circulation, thick nails or ingrown toenails, or on drugs that affect blood clotting. During foot care, check for cracks & sores between toes (could result in serious infection, if untreated). Put on non-skid footwear after applying lotion to feet.
* Clothing is changed after the bath & whenever wet or soiled.
  + Provide for privacy.
  + Encourage person to do as much as possible.
  + Encourage person to choose what to wear.
  + Remove clothing from strong side first.
  + Put clothing on weak (affected) side first.
  + Support arm or leg when removing or putting on a garment.

# Vital Signs

* Accuracy is essential. If you are unsure of measurements, promptly ask nurse to take them again.
* Report the following at once:
  + Significant change from prior measurement.
  + Vital signs above or below normal range.
* Body temperature
  + Can be measured using Fahrenheit (F) & centigrade or Celcius (C).
  + Sites include mouth (oral), rectum, axilla (under arm), tympanic membrane (ear), & temporal artery (forehead).
  + Normal ranges for temperature depends on site:
    - Oral: 97.6°F – 99.6°F.
    - Rectal: 98.6°F – 100.6°F.
    - Axillary: 96.6°F – 98.6°F.
    - Tympanic membrane: 98.6°F.
    - Temporal artery: 99.6°F.
  + Older persons have lower body temperatures than younger persons.
  + Glass thermometers
    - If mercury-glass thermometer breaks, must follow procedures for handling hazardous material.
    - Rectal thermometers only for rectal temperatures.
    - Rinse the thermometer under cold, running water if it was soaking in disinfectant. Dry from stem to bulb with tissues.
    - Discard if broken, cracked, or chipped.
    - Shake down to below 94°F or 34°C before using it.
  + Taking temperatures
    - Oral: Glass thermometer remains in place 2 -3 minutes.
    - Rectal: Lubricate bulb end, insert 1” into rectum. Hold in place for 2 minutes, or per agency policy.
    - Axillary: Axilla must be dry. The glass thermometer stays in place 5 – 10 minutes or per agency policy.
  + Electronic thermometers
    - Cannot be used with ear drainage or wax blockage. Gently insert in ear canal – should register in 1 – 3 seconds.
    - Temporal artery thermometer measures temperature by scanning temporal artery in forehead in 3 – 4 seconds.
* Pulse
  + Adult rate should be between 60 – 100 beats per minute.
    - **Tachycardia:** Heart rate > 100 bpm, report immediately.
    - **Bradycardia:** Heart rate < 60 bpm, report immediately.
  + Rhythm should be regular. Report & record irregular pulse rhythm.
  + Force should be recorded (strong, full, bounding, weak, thread, feeble).
  + Radial pulse is used for routine vital signs. Use middle 2 – 3 fingers, not thumb. Count pulse for 30 seconds & multiply by 2. If irregular, count for 1 minute. Report & record if pulse is regular or irregular.
  + Apical pulse is on left side of chest slightly below nipple. Count for 1 minute.
* Respirations
  + Healthy adult rate is 12 – 20 respirations per minute. Healthy respirations are quiet, effortless, & regular. Both sides of chest rise & fall equally.
  + Count respirations while person is at rest, right after taking pulse.
  + Count respirations for 30 seconds & multiply by 2. If abnormal pattern is noted, count for full minute.
  + Report & record, rate, equality & depth, regular or irregular, pain or difficulty breathing, any respiratory noises or abnormal patterns.
* Blood pressure
  + **Systolic pressure** (upper number) should be less than 120 mmHg.
  + **Diastolic pressure** (lower number) should be less than 80 mmHg.
  + **Hypertension**: blood pressure measurements that are above 140mmHg (systolic) or 90 mmHg (diastolic). Report systolic pressure above 120 mmHg. Also report diastolic pressure above 80 mmHg.
  + **Hypotension**: Systolic blood pressure below 90 mmHg &/or diastolic blood pressure below 60 mmHg. Either situation should be reported.
* Weight
  + Person wears only gown or pajamas. No footwear is worn.
  + Person must void before weighing.
  + Person should be weighed at the same time of day, usually before breakfast.
  + Use the same scale for daily, weekly, or monthly weights.
  + Always balance the scale at zero before weighing the person.

# Nutrition

* Food & water are basic human needs. Poor diet & eating habits cause healing problems & affect physical & mental function, & increase risk for accidents, injuries, & infection.
* **Nutrients** are substances that the substances found in food that the body uses for growth, energy, & health.
  + **Protein:** needed for tissue growth & repair. *Sources include meat, fish, poultry, eggs, milk & milk products, cereals, beans, peas, & nuts.*
  + **Carbohydrates**: provide energy & fiber for bowel elimination. *Sources include fruits, vegetables, breads, cereals, & sugar.*
  + **Fats**: Provide energy, add flavor, & help the body use certain vitamins. *Sources include meats, lard, butter, shortening, oils, milk, cheese, egg yolks, & nuts.*
  + **Vitamins**: needed for certain body functions. The body stores vitamins A, D, E, & K. Vitamin C & B complex vitamins must be ingested daily.
  + **Minerals**: are needed for bone & tooth formation, nerve & muscle function, fluid balance, & other body processes.
  + **Water**: needed for all body processes.
* Factors affecting eating & nutrition:
  + Age: changes occur in digestive system with aging.
  + Culture: influences dietary practices, food choices, & food preparation.
  + Religion: as above.
  + Appetite: Illness, drugs, anxiety, pain, & depression can cause loss of appetite. Unpleasant sights, smells, & thoughts can also interfere.
  + Personal choice: influenced by foods served in the home.
  + Body reactions: People avoid foods that cause allergic reactions, nausea, vomiting, indigestion, diarrhea, gas, or headaches.
  + Illness: Needs may , appetite may  during illness & recovery.
  + Disability: Disease or injury can affect hands, wrists, & arms, making adaptive equipment necessary for independent eating.
* OBRA has requirements that affect food service in long term care settings.
  + Individual nutritional & dietary needs must be met.
  + Diet must be well-balanced, nourishing, tasty, & well-seasoned.
  + Food must be appetizing: attractive, with appealing aroma.
  + Hot food must be served hot; cold food must be served cold.
  + Food must be prepared to meet special needs, including prescription diets & grinding, chopping, & cutting foods.
  + Alterative foods of similar nutritional value must be provided if the person refuses the food served.
  + Each person receives 3 meals per day & is offered a bedtime snack.
  + The center provides adaptive equipment & utensils.
* Special diets
  + **Sodium-controlled**: No added salt when eating, limited salt used in cooking, omitting high sodium foods.
  + Diabetes meal planning: involves eating meals & snacks at regular times, considering food preferences with consistent calorie & nutrient intake, & careful recording & reporting of what person does & doesn’t eat so that appropriate adjustments can be made.
  + **Dysphagia**: used for people with difficulty swallowing to prevent **aspiration** (food or fluid entering the lungs). Person often needs thickened liquids & should be fed according to care plan. Immediately report choking, coughing, or difficulty breathing during or after meals.
* Fluid balance is needed for health. Fluid taken in (**input**) & amount of fluid lost (**output**) must be equal. If intake exceeds output, body tissues swell (**edema**). If fluid output exceeds intake, there is a decrease in the amount of water in body tissues (**dehydration**). Common causes for dehydration are poor intake, vomiting, diarrhea, bleeding, & excessive sweating.
* Normal fluid balance requires 2000 – 2500 ml of fluid intake per day. 1500 mls of fluid daily are needed to survive. Older persons may have  sense of thirst, even though their bodies still need water. Offer fluids per care plan.
* Special fluid orders (per physician) include:
  + **Encourage fluids**: Person drinks an  amount of fluid.
  + **Restrict fluids**: Fluids are limited to a certain amount.
  + **NPO (nothing per mouth)**: The person cannot eat or drink.
  + **Thickened liquids**: All liquids are thickened, including water.
* **I & O**: All fluids taken by mouth are recorded, including foods that melt at body temperature (ice cream, pudding, gelatin, etc). Output includes urine, vomitus, diarrhea, & wound drainage.
  + To measure: 1 oz = 30 mL
  + Must know serving sizes of bowls, dishes, cups, & other containers.
  + I & O record is kept at bedside. Record amounts carefully in correct columns & total at the end of the shift. Totals are recorded in person’s chart.
  + Urinal, commode, bedpan, or specimen pan is used for voiding. Remind person not to void in toilet & not to put toilet paper in the receptacle.
* Preparing for meals: assist with elimination needs, provide oral hygiene & make sure dentures, hearing aids, & glasses are in place, assist with handwashing, & position person upright & comfortably for meals.
* Serve meals promptly to be sure hot food is hot & cold food is cold.
* Feeding the person may be necessary, but embarrassing for the resident.
  + Let them do as much as possible.
  + Serve food in the order the person prefers. Offer fluids often.
  + Tell visually impaired person what is on their tray. Describe what you are offering, or use numbers on clock to describe position of foods for persons who feed themselves.
  + Use teaspoon to feed. No straws with thickened liquids.
  + Allow time for privacy & prayer if this is something the resident wants.
  + Make mealtime social. Face the person & engage in pleasant conversation.
  + People eat better if not rushed.
  + Wipe hands, face & mouth as needed during the meal.
  + Report & record amount & kind of food eaten, c/o nausea & dysphagia, S & Sx of dysphagia & aspiration.
* Calorie counts are kept for some people, using a flow sheet. Note what & how much a person ate. A nurse or dietician converts these portions into calories.
* Residents need fresh drinking water. Agency policies dictate how fresh water is provided.
  + To prevent spread of microbes, label water pitchers with person’s name & room #.
  + Do not touch rim or inside of water glass, cup, or pitcher.
  + Do not let ice scoop touch rim or inside of water glass, cup, or pitcher.
  + Place ice scoop in a holder or on a towel, not in ice container or dispenser.
  + Make sure water pitcher & cups are clean & free of cracks & chips.

# Basic needs; comfort, rest, & sleep

* The whole person must be considered when care is provided. Physical, social, psychological, & spiritual parts are interwoven & can’t be separated (**holism**).
* Address people with dignity & respect.
  + Use appropriate titles (Mr. Gonzalez, Miss Turner, etc).
  + Do not use first names or nicknames, unless the person asks you to.
  + Do not use pet names or terms of endearment (Honey, Grandma, etc).
* A **need** is something necessary or desired for maintaining life or well-being.
* According to Maslow, basic needs must be met for a person to survive & function.
  + Physiological needs: oxygen, food, water, elimination, rest, & shelter.
  + Safety/security needs: relate to feeling fo being safe from harm or danger.
  + Love/belonging needs: need to experience love, closeness, affection, & meaningful relationships with others.
  + Self-esteem needs: relate to thinking well of oneself or seeing oneself as useful & having value. Illness & disability often  self-esteem.
  + Self-actualization needs: learning, understanding, & creating to the limit of a person’s capacity. Rarely, if ever, totally met.
* Sleep needed for tissue healing & repair to occur. It refreshes & renews a person, lowering tension, stress, & anxiety. It provides energy & restores mental alertness. People think & function better after sleep.
  + Illness:  need for sleep.
  + Nutrition: sleep needs  with weight gain. Caffeine prevents sleep.
  + Exercise: Being tired after exercise helps sleep, but exercise within 2 hours of bedtime interferes with sleep.
  + Emotional problems interfere with sleep.
  + Drugs for anxiety, depression, & pain can cause sleep. Sleeping pills promote sleep.
  + Change in environment can disrupt sleep.
  + Flexible bedtime, comfortable room temp, assistance to void before going to bed all help promote sleep.
  + **Insomnia**: chronic condition: person can’t sleep or stay asleep all night.
  + **Sleep deprivation**: Sleep is interrupted, so amount & quality of sleep are .
  + **Sleep-walking** is when a person leaves bed & walks around. They need to be protected from injury. Guide them back to bed. Awaken them gently.

# Admissions, Transfers, Discharges, & Assisting Residents After Surgery

* Admission, transfer, & discharge are critical events requiring privacy & confidentiality, understanding & communicating with the person, communicating with the health team, demonstrating kindness, courtesy, & respect for the resident & his/her property.
* CNA role in admission (official entry into the agency) involves:
  + Prepping the room
    - Thermometer, sphygmomanometer & stethoscope, & admission form on overbed table.
    - Admission kit, bedpan & urinal, towels & washcloth, gown or pajamas on bedside stand.
    - Water pitcher, cup, & urine specimen container (optional; on bedside stand or overbed table.
    - If person is arriving by stretcher, make surgical bed, raised to highest level.
    - If person is arriving by wheelchair or ambulatory, leave bed in low position, closed in nursing center or open in hospital.
    - Attach signal light to bed linens.
  + Making a good first impression
    - Greet person by name & title
    - Introduce yourself & title
    - Make roommate introductions
    - Treat person with dignity & respect
  + Admission tasks that may be delegated to CNA
    - Measuring height & weight
    - Measuring vital signs
    - Completing a clothing & belongings list
    - Orienting person to the room, the nursing unit
    - Obtaining a urine sample, if ordered
* Transfers (moving a person from one room or nursing unit to another)
  + CNA role might include
    - Transporting the person by WC, stretcher, or bed.
    - Supporting & reassuring the person
    - Introducing the person to staff & roommate.
    - Helping the person load belongings & care equipment onto a utility cart & then arranging them in the new room.
  + CNA **does not**
    - Explain reasons for transfer: that is responsibility of nurse, physician, or social worker.
    - A nurse will transport the medical record and medications to the new unit.
* Discharge (the official departure of a person from the agency)
  + CNA role might include
    - Helping the person dress & pack (be sure nothing is left behind).
    - Check off clothing list & personal belongings list. Give to nurse.
    - Load personal items on utility cart.
    - Help person into wheelchair & take the person to exit area.
    - Help person into car & help put the person’s belongings in the car.
    - Strip the bed, clean the unit.
    - Make a closed bed for the next resident.
  + CNA **will not** (these are nursing responsibilities):
    - Provide prescriptions or discharge instructions
    - Get valuables from the safe
    - Arrange for home care, equipment, therapies
    - Deal with residents who want to leave the agency without the doctor’s permission.
* CNA role after a resident has surgery
  + Room preparation includes
    - Make a surgical bed
    - Move furniture out of way for stretcher
    - Place thermometer, stethoscope & sphygmomanometer, kidney basin, bed protector, vital signs sheet, I & O record, IV pole at bedside
  + Vital signs are usually measured frequently, depending how long it has been since surgery.
  + Person is positioned for comfort (depending on surgical site) & to prevent complications
    - Positioning restrictions may be ordered
    - Repositioning is done at least every 1 – 2 hours to prevent respiratory & circulatory complications
    - Turning can be painful, so pillows & other positioning devices are used for support. Movement must be smooth & gentle.
  + To prevent respiratory complications of **pneumonia** (inflammation & infection of lung) & **atelectasis** (collapsed potion of lung):
    - Coughing & deep breathing exercises are encouraged every 1 – 2°.
    - Use of Incentive spirometer also helps prevent respiratory complications.
  + To prevent circulatory complications of **thrombus** (blood clot) formation & **pulmonary embolism** (clot that dislodges & travels to lungs), circulation must be stimulated.
    - Leg exercises (circling toes, plantar- & dorsiflexing toes, flexing & extending one knee at a time, & raising & lowering leg off bed) implemented according to doctor’s orders & nursing instruction
    - Elastic stockings are applied & removed per care plan to promote venous blood return to heart.
      * Nurse measures & orders stocking in thigh- or knee-high length
      * Opening near toes is used to check skin color & temperature
    - Sequential compression device wrapped around leg & attached to a pump for intermittent inflation.
  + Early ambulation starts with dangling & s gradually per nurse’s instruction
  + Nutrition & fluids progress from NPOclear liquidsfull liquidsregular
  + Elimination may be altered by inactivity & pain meds. May have temporary catheter. Report problems with constipation.
  + Comfort & pain relief measures are important to progress of recovery
  + Personal hygiene is important for physical & mental well-being.